STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

February 27, 2009

GENERAL LETTER NO. 6-AP-84

ISSUED BY: Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 6, ***INCOME MAINTENANCE PROGRAMS APPENDIX***, pages 36d, 118, 184, 247 through 250, 253, and 254, revised; and the following forms:

427-0415	*Agreement for Telephone Hearing*, revised
RC-0033	*Desk Aid*, revised
470-0490	*Notice of Decision: Medical Assistance or State Supplementary Assistance*, revised
470-0288	*Notice of Disqualification*, revised

Summary

This chapter is revised to:

- Update the following forms as they have been simplified so they are easier to read and understand:
  - 427-0415, *Agreement for Telephone Hearing*
  - 470-0288, *Notice of Disqualification*
- Update RC-0033, *Desk Aid*, to reflect the change in poverty levels for QMB, SLMB, expanded SLMB, and QDWP.
- Update the instructions to reflect availability of the following forms:
  - 470-2255, *Food Assistance Work Rules*
  - 470-4364(M), *IowaCare Renewal Application* (manual)
- Revise form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, to convert the form to FileNet and add "medical institution" to the check box on cancellation.

Effective Date

Changes to the *Desk Aid* are effective March 1, 2009. All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 6, Appendix, and destroy them:

Page	Date
427-0415 (before p. 13)	6/01
36d	October 19, 2007
RC-0033 (before p. 69)	1/09
118, 184	January 9, 2009
470-0490	1/07
247, 248	February 1, 2008
249, 250	April 23, 2002
470-0288	2/07
253	March 20, 2001
254	February 1, 2008

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Iowa Department of Human Services

Agreement for Telephone Hearing

Complete this form before your Intentional Program Violation (IPV) hearing and return it to your local Department of Human Services (DHS) office.

If you have questions about this form, call the DHS Appeals Section at (515) 281-8774.

Your Section

Read, sign, and date the statement below:

I understand that I have the right to:

- Have an in-person hearing, but I agree to a telephone hearing instead
- Present my case
- Bring a lawyer
- Look at the evidence
- Ask questions to anyone at the hearing
- Turn in evidence

Signature	Date

Witness's Section

I witnessed the person above read, sign, and date this statement.

Witness's signature	Date

Worker's Section

Please fill in the boxes below and return this form to the Department of Inspections and Appeals Division of Administrative Hearings.

IPV Number	Case Number

AWARE Hotline Complaint, Form 427-0578

Purpose	Form 427-0578 is used: ♦ To exchange information electronically between the Department of Inspections and Appeals (DIA) and DHS about hotline tip referrals. ♦ As referral mechanism for Front End Investigations and for DIA Fraud Investigation. See 4-G, DIA Hotline Referrals, 7-G, Acting on Automated Reports, and 8-G, Acting on DIA Hotline Referral, for additional information.
Source	Form 427-0578 is a template that originates with DIA. Use of the template is limited to hotline tip referrals.
Completion	DIA completes Section A when it receives a hotline tip referral involving a former or current FIP, Food Assistance, or Medicaid client. The DHS Field Operations Support Unit completes Section B, and the IM worker completes Section C.
Distribution	Upon completion of Section A, DIA e-mails the form to the Field Operations Support Unit. The Field Operations Support Unit completes Section B and e-mails the form to the assigned IM worker, with electronic copies to the IM supervisor and the IM supervisor 2 for the service area. After taking necessary action, the worker completes Section C and returns the form via e-mail to the Field Operations Support Unit, with an electronic copy to the IM supervisor 2. The Field Operations Support Unit maintains a log of hotline tip referral activities. **Note:** When the hotline tip results in a referral to Front End Investigations or to Fraud Investigations, the returned form serves as the referral to the respective unit. Keep a paper copy of each completed referral in the case record.
Data	Complete Section C as appropriate.

Iowa Department of Human Services

DESK AID

COVERAGE GROUP	RESOURCE LIMIT	MONTHLY INCOME LIMITS							
Food Assistance	$3,000 if one or more age 60 or older or disabled $2,000 all other HH	Household Size							
			1	2	3	4	5	6	7
		Gross	$ 1,127	$ 1,517	$ 1,907	$ 2,297	$ 2,687	$ 3,077	$ 3,467
		Net	$ 867	$ 1,167	$ 1,467	$ 1,767	$ 2,067	$ 2,367	$ 2,667
		Max Allotment	$ 176	$ 323	$ 463	$ 588	$ 698	$ 838	$ 926
FIP	$2,000 per applicant HH $5,000 per recipient HH	Household Size							
			1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
FMAP and FMAP-Related Medicaid	$2,000 per applicant HH $5,000 per recipient HH	Household Size							
			1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
Mothers and Children (MAC) Medicaid *	$10,000 per HH	Household Size							
		Poverty Level	1	2	3	4	5	6	7
		200% Pg women/infants	$ 1,734	$ 2,334	$ 2,934	$ 3,534	$ 4,134	$ 4,734	$ 5,334
		For each additional household member add $600.							
		133% Children 1-18	$ 1,153	$ 1,552	$ 1,951	$ 2,350	$ 2,749	$ 3,148	$ 3,547
		For each additional household member add $399.							
Medically Needy Medicaid *	$10,000 per HH	Medically Needy Income Level (MNIL) by Household Size							
		1	2	3	4	5	6	7	
		$ 483	$ 483	$ 566	$ 666	$ 733	$ 816	$ 891	

	1	2	3	4	5	6	7
100% Poverty Level	$ 867	$ 1,167	$ 1,467	$ 1,767	$ 2,067	$ 2,367	$ 2,667
	For each additional household member add $300.						

	1	2	3	4	5	6	7
200% Poverty Level FIP Diversion	$ 1,734	$ 2,334	$ 2,934	$ 3,534	$ 4,134	$ 4,734	$ 5,334
	For each additional household member add $600.						

SSI-Related Medicaid *

$2,000 for 1
$3,000 for a couple

Household Size (Couple in own home)

1	2
$ 674	$ 1,011

Medically Needy Medicaid *

$10,000 per HH

Medically Needy Income Level (MNIL) Household Size

1	2	3	4	5	6	7
$ 483	$ 483	$ 566	$ 666	$ 733	$ 816	$ 891

QMB * (A Medicare Savings Program)

$4,000 for 1
$6,000 for a couple

	Poverty Level	Household Size: Individual	Household Size: Couple
Effective 3/1/09	100%	$ 903	$ 1,215

SLMB * (A Medicare Savings Program)

$4,000 for 1
$6,000 for a couple

Poverty Level	Household Size	Income Over	But Less Than
Effective 3/1/09	Individual	$ 903	$ 1,083
Over 100% but less than 120%	Couple	$ 1,215	$ 1,457

Expanded SLMB * (QI-1) (A Medicare Savings Program)

$4,000 for 1
$6,000 for 2

Poverty Level	Household Size	Income	But Less Than
Effective 3/1/09	Individual	$ 1,083	$ 1,219
120% but less than 135%	Couple	$ 1,457	$ 1,640

QDWP Medicaid * (A Medicare Savings Program)

$4,000 for 1
$6,000 for a couple

	Poverty Level	Household Size: Individual	Household Size: Couple
Effective 3/1/09	200%	$ 1,805	$ 2,429

MEPD Medicaid for Employed People with Disabilities

$12,000 for 1
$13,000 for 2

Net countable income is less than 250% FPL

MEPD Income Limit Household Size

1	2	3	4	5	6	7	8
$ 2,167	$ 2,917	$ 3,667	$ 4,417	$ 5,167	$ 5,917	$ 6,667	$ 7,417

Monthly Medicare Part B Premium
(Effective 1-1-2008)

$96.40

* Note: Compare net countable income to the income limits.

Medicaid for Employed People With Disabilities (MEPD)

	MONTHLY INCOME LIMITS						
	MEPD Household Size						
	1	2	3	4	5	6	7
Below 250% FPL	$ 2,167	$ 2,917	$ 3,667	$ 4,417	$ 5,167	$ 5,917	$ 6,667

2008 MEPD Premiums Effective July 1, 2008

If the gross monthly income of the person getting MEPD is:	FPL	Premium Amount
$ 1,300 or less	At or below 150%	**$ 0**
Above: $ 1,300	**Above:** 150%	$ 29
1,560	180%	53
1,907	220%	80
2,080	240%	110
2,271	262%	140
2,756	318%	170
2,964	342%	200
3,380	390%	230
3,684	425%	260
3,987	460%	291
4,334	500%	323
4,750	548%	354
5,261	607%	392
5,772	666%	430
6,289	725%	471
$ 7,142 and above	824%	535

IowaCare

	MONTHLY INCOME LIMITS						
	IowaCare Household Size						
	1	2	3	4	5	6	7
At or below 200% FPL	$ 1,734	$ 2,334	$ 2,934	$ 3,534	$ 4,134	$ 4,734	$ 5,334
Below 300% FPL	$ 2,600	$ 3,500	$ 4,400	$ 5,300	$ 6,200	$ 7,100	$ 8,000

2008 IowaCare Premiums

When the household's monthly income is at or below:	FPL	Each member's monthly premium is:
$ 867	100%	No cost
954	110%	$ 43
1,041	120%	47
1,128	130%	52
1,214	140%	56
1,301	150%	60
1,388	160%	64
1,474	170%	69
1,561	180%	73
1,648	190%	77
1,734	200%	82

Food Assistance Work Rules, Form 470-2255 and 470-2255(S)

Purpose	Form 470-2255, *Food Assistance Work Rules*, is used to notify each mandatory work registrant what the registrant's rights and responsibilities are and the consequences of failure to comply with the requirements.
Source	The English version of form 470-2255 is printed in pads of 50 two-part carbonized sets. Order supplies from Iowa Prison Industries at Anamosa. The form may also be completed on line using the template on the DHS Intranet eForms web page. The Spanish version can be printed from the on-line manual or photocopied from the paper manual.
Completion	The IM worker issues this form to every mandatory work registrant when: ♦ An application is approved, ♦ A case is approved for recertification, ♦ A client loses exempt status for work registration due to a change in circumstances, or ♦ A new household member who is a mandatory work registrant is added.
Distribution	Give or mail the one copy of the form to the client. At the application or recertification interview, give the household representative the a copy this form for each mandatory registrant in the household. File the other copy of the form in the registrant's case file.
Data	Enter the mandatory work registrant's name and the date the form was given or mailed to the registrant.

IowaCare Renewal Application, Form 470-4364, 470-4364(S), 470-4364(M), or 470-4364(MS)

Purpose	The *IowaCare Renewal Application* is designed for members to use to renew their IowaCare coverage.
Source	In most cases, form 470-4364 is generated automatically by the Automated Benefit Calculation (ABC) system. Form 470-4364(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen. Income maintenance workers may issue a duplicate from the ABC system. The manually issued English version, form 470-4364(M), may also be completed on line using the template on the DHS Intranet eForms web page. Supplies of the manually issued Spanish version, form 470-4364(MS), may be printed or photocopied from the sample in the manual.
Completion	Central Office mails form 470-4364 to members whose IowaCare certification period is ending, along with Comm. 260, "*Do You Need Help Paying for Your Prescription Drugs?*." The IowaCare member completes the form. A friend, relative, authorized representative, or DHS staff may help if needed. The member must sign the form. When both spouses are in the home, both must sign.
Distribution	The member keeps pages 5 and 6. If the member wants a copy of the application, photocopy the form for the member. Date-stamp the original application upon receipt. For the purpose of Medicaid, the application date is the date the agency received the application.
Data	The form requests information about the household's composition, income, resources, and insurance.

Iowa Department of Human Services

Notice of Decision: Medical Assistance or State Supplementary Assistance

Case No.	Date
Program	County

Action: ☐ Approval ☐ Review ☐ Transfer ☐ Redetermination ☐ Denial ☐ Cancellation

,

Facility Name
Worker Name Worker Name
Worker Phone # Worker Phone

ACTION TAKEN

☐ Your application for Medical Institution or State Supplementary Assistance has been approved effective . You are required to contribute toward the cost of your care beginning . You are required to contribute per month thereafter.

☐ You have been approved for Medical Assistance effective

☐ Your application has been denied.

☐ As a result of your transfer from one facility to another you are required to pay to and to . The monthly amount thereafter is .

☐ A review or redetermination of your circumstances indicates that you continue to be eligible for assistance. Effective , you are required to contribute per month.

☐ Your Medical Institution or State Supplementary Assistance has been canceled effective

☐ Your Medical Assistance has been canceled effective

This action was based on policy in the Department Employees' Manual at:

If you do not agree with this decision, see page 2 of this form for your rights.

Comments by worker:

PAYMENT COMPUTATION

Income From		Amount
	+	
	+	
Total Income		
Less Diversions	-	
Client Participation	=	

Deductions and Diversions of Income for Spouse and Dependent, Unmet Medical Needs, and Home Maintenance Allowance, if applicable:

Personal Allowance	
Total Diversions	

You Have the Right to Appeal

What is an appeal?
An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?
Filing an appeal is easy. You must appeal in writing by doing **one** of the following:

- Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/; **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?
You must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?
You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date of a decision or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?
You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?
You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:
Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

Notice of Decision: Medical Assistance or State Supplementary Assistance, Form 470-0490

Purpose

The local office uses form 470-0490 to notify an applicant or recipient of SSI-related Medicaid or State Supplementary Assistance when the Department takes one of the following actions:

- Assistance is approved.
- An application is denied.
- A recipient transfers from one program or facility to another.
- Assistance continues after a review.
- Assistance is changed because of a redetermination.
- Assistance is canceled.

Source

Complete this form on line using the template on the DHS Intranet eForms web page.

Completion

The IM worker responsible for the case completes this form when:

- A computer-generated notice cannot be issued, according to case action instructions in Chapter 14-B(9).
- The worker chooses to issue a manual notice instead of a computer-generated one.

Distribution

Send the original to the client and file a copy in the case record. Make another copy and send to the guardian, conservator, or payee, when there is someone acting in this capacity on behalf of the client.

Data

Complete the form as follows:

- Case number. Enter the case number.
- Program. Identify the program as follows:

Entry	Used For
ICF	Nursing facility care
RCF	Residential care
Skilled	Skilled nursing care
Hospital	Hospital care only
Family-life	Family-life home
In-home care	In-home health-related care

Entry	Used For
Medical	SSI Newborns Widows and widowers ineligible for SSI or SSA due to actuarial increase People who decline SSI or SSA cash People ineligible for SSI or SSA because of Social Security COLA (503)
HCBS	Home- and community-based services

- Indicate the name of the facility involved.

Complete the section entitled "Action taken" by checking the box of each applicable item and entering other information as follows:

- **Approvals for Medicaid institution care or State Supplementary Assistance:**
  - The effective date of approval shall be the date of application or the date of eligibility, whichever is later.
  - Enter the amount of first-month client participation.
  - Enter the beginning date of client participation.
  - Enter the amount of ongoing client participation.
- **Medical assistance approval**: The effective date of medical assistance shall be the first day of the month in which eligibility is established.
- **Denials:** Check the third box if an application is denied or withdrawn before approval.
- **Transfer from one facility to another:**
  - Enter the amount the client is required to pay to the previous facility.
  - Enter the amount the client is required to pay for first month's participation in the new facility (if any).
  - Enter the amount of ongoing client participation.

- **Review or redetermination:**
  - Enter the effective date of ongoing client participation.
  - Enter the amount of client participation resulting from the recertification.
- **State Supplementary Assistance cancellation**: Enter the date that the State Supplementary Assistance is canceled.
- **Medicaid cancellation:**
  - Enter the effective date of cancellation of medical assistance. This date should be the first of the month unless the recipient died. Then enter the date of death.
- **All actions:**
  - **Legal reference:** Enter the title and chapter number of the manual reference. Use the title of the paragraph in the manual that the decision was based on. Also enter the rule reference for this section.
  - **Comments by worker:** Use this space to explain the specific reason for the action taken and any other comments which the worker feels are pertinent to the applicant or recipient. The worker may attach a separate sheet to explain the action.

The form will populate the following fields:

- The date field populates with the current date as the date the action is taken.
- The name of the county where the local office is located.
- The client's name and address in the box on the upper left corner of the form.
- Your name and phone number.

The payment computation section serves as a record for determining client participation for a client residing in an ICF, SNF, or RCF, receiving in-home health-related care, or receiving home- and community-based service care. It may also be used to compute eligibility and state warrant in family life home cases.

- List and total all gross countable income.
- List all allowable deductions and diversions and add them to the persona0l allowance to determine total deductions.
- Click the checkbox to change the personal allowance to the RCF or veterans amount.
- The form will calculate the client's participation by subtracting the diversions, deductions, and personal allowance from the total income.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Interoffice Memorandum

To/Office:
Attention:
From: Ronda Johnson, DHS Liaison for Appeals
Subject: Appeal #
Case #

Instructions for Issuing a *Notice of Disqualification*

Attached is a *Notice of Disqualification* (470-0288). This must be sent after a Final Decision is issued on this appeal. Our records show this is the respondent's 1st violation. If you do not agree with the number of IPV violations, please call the Appeals Section at (515) 281-8774.

You must send this *Notice of Disqualification* to the respondent.

For respondents who currently get Food Assistance, you will need to impose the disqualification the first month that action can be taken by making entries into the IABC system. Then, mail the *Notice of Disqualification*.

For respondents who are not currently getting Food Assistance, send the notice within 10 days of the date on the Final Decision.

Here is how you fill out the *Notice of Disqualification:*

1. Click on "Tools", then choose the "Protect Document" option. Next, click on "Forms" and then click "OK". This will enable you to type in the needed information. Otherwise, you can just print it off and fill out the notice by hand.
2. Click on the gray boxes at the top of the letter and fill out the "Notice date," "County," "Worker name," "Worker number," and "Phone" fields.
3. Enter whether this is the respondent's 1st, 2nd, or 3rd violation by clicking on the dropdown box, and then clicking on the correct number.
4. Type in the beginning and ending date of the disqualified period, if applicable. For respondents not currently getting Food Assistance, the beginning date will be the month following the month the Final Decision is issued.
5. Click on the check box and complete the portion for the rest of the household's Food Assistance eligibility.
6. Type or sign your name at the end of the letter.
7. Make two copies. Send the original to the respondent, keep one copy in your case record and fax the other one to the Appeals Section at (515) 281-4597 for the appeal file.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Notice of Disqualification

Notice date:
County:
Worker number:
Worker name:
Phone:

Dear

You committed a 1st intentional program violation (IPV). Because of this, you will not get Food Assistance for the following amount of time:

☐ A period of 12 months beginning _____ and ending _____.

☐ You will not get Food Assistance again because you have a lifetime sanction.

The State or Federal governments may also take you to court or make you pay back the amount of Food Assistance your household got in error.

☐ The rest of your household can get Food Assistance beginning _____ and ending _____. The amount of Food Assistance your household can get may change based on other eligibility factors. If Food Assistance does change, the household will get a new Notice of Decision. Once the certification period is over, your household will have to fill out a new application at your local DHS office.

☐ The rest of your household may be able to get Food Assistance, but will have to fill out a new application at your local DHS office.

☐ The rest of your household can no longer get Food Assistance.

If you believe the decision about your household's Food Assistance is wrong, you may file an appeal. If you have questions, call me at the number listed above.

Thank you for your cooperation,

Income Maintenance Worker

Notice of Disqualification, Form 470-0288

Purpose

Form 470-0288 is used to:

- Notify a person who has been found to have committed an intentional program violation of the period of disqualification.
- Notify the remaining household members, if any, of the benefits they will receive during the period of disqualification, or that they must reapply for Food Assistance because the certification period has expired.

Source

The form is an electronic template generated by the DHS Appeals Section and e-mailed to the IM worker.

Completion

The Appeals Section generates this form when an administrative law judge finds a client guilty of intentional program violation in the Food Assistance program.

The local office may also request a form from the Appeals Section when the Department of Inspections and Appeals, Investigations Division, has notified the worker that a court has found that the household member committed an intentional program violation.

The Appeals Section completes the address and identifying information. The IM worker completes the notice fields.

Distribution

The Appeals Section sends the form to the IM worker by electronic mail for completion and printing. The IM worker:

- Sends the original to the client.
- Places a copy in the client's file.
- Sends a copy to the Appeals Section once the disqualification is implemented.

Data

The Appeals Section completes the names, addresses, appeal numbers, and salutations. The IM worker completes the length of sanction and the effect on household benefits, following the instructions given, and signs the form.

Notice of Employment, Form 470-0820

Purpose	The PROMISE JOBS unit uses the *Notice of Employment* to notify the IM worker when a PROMISE JOBS participant begins employment.
Source	PROMISE JOBS staff complete this form using the template provided by DHS.
Completion	The PROMISE JOBS worker completes Part A of the form when a participant begins or changes employment. IM staff complete Part B, unless: ♦ You have already sent the PROMISE worker form 470-2844, *Employer's Statement of Earnings*, from this employer, or ♦ You have the *Employer's Statement of Earnings* completed by the new employer and attach a copy of it to the *Notice of Employment*. **Note:** When you become aware of a mandatory or volunteer PROMISE JOBS participant who has begun, ended, or changed employment, you should send a copy of the *Employer's Statement of Earnings* or equivalent verification to the PROMISE JOBS worker. If you don't know who the PROMISE JOBS worker is, send the verification to the PROMISE JOBS office designated under the coordination arrangement of the PROMISE JOBS local service plan.
Distribution	After completing Part A, PROMISE JOBS staff sends the form to the IM worker. PROMISE JOBS keeps a control copy. The IM worker: ♦ Completes Part B (or attached from 470-2844), ♦ Makes a copy to file in the participant's FIP case record, and ♦ Returns the form to the local PROMISE JOBS unit.